

Ocrevus Zunovo™ (ocrelizumab and hyaluronidase-ocsq) Referral Form**Preferred Clinic** (select one):**PATIENT INFORMATION**

New Referral

Updated Referral

Referral Renewal

DOB:	Patient Name:	Patient Phone:
Patient Address:	Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:
ICD-10 Code (required): SEE BELOW	Last Treatment Date:	Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:
Physician Preferred Method of Contact:	Email:	Fax:	Phone:

STANDING ORDERS☒ Infusion to be administered per Vivo protocols.**LABORATORY ORDERS**

CBC w/ diff every _____

CMP every _____

OTHER _____

Vivo Infusion will perform pregnancy screening prior to every infusion per Vivo policyPREMEDICATIONS******It is recommended to pre-medicate orally with 20 mg of dexamethasone (or an equivalent corticosteroid) and an antihistamine****

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25 mg 50 mg PO

dexamethasone 20mg PO

Other: _____

Dose: _____ Route: _____

OCREVUS ZUNOVO ADMINISTRATION

920 mg/23,000 units (920 mg ocrelizumab and 23,000 units of hyaluronidase) administered as a single 23 mL subcutaneous injection in the abdomen over approximately 10 minutes every 6 months

REQUIRED ICD-10 CODE

G35A Relapsing-remitting multiple sclerosis

G35B0 Primary progressive multiple sclerosis, unspecified

G35BS Active primary progressive multiple sclerosis

G35B2 Non-active primary progressive multiple sclerosis

G35C0 Secondary progressive multiple sclerosis

G35C1 Active secondary progressive multiple sclerosis

G35C2 Non-active secondary progressive multiple sclerosis

G35D Multiple sclerosis, unspecified

REQUIRED DOCUMENTATION

Patient Demographics	HepB Surf Ag (within 12 months)
Insurance Card/Information	Hep B Core AB (within 12 months)
Progress Notes Supporting DX	Current Medication List and H&P
Quantitative Immunoglobulin	Complete Metabolic Panel

Provider Name (Print)

Provider Signature

Date

Email Referrals To: referrals@vivoinfusion.com OR Fax Below**Have a Question? Call (720) 902-4111**

Colorado: 303-418-4679

Michigan: 833-957-2188

New York: 800-540-1852

Texas: 469-340-0044

Connecticut: 203-724-4838

Minnesota: 763-290-0903

Ohio: 216-400-0674

Virginia: 804-500-5941

Florida: 904-930-4211

Nevada: 702-489-5744

Oklahoma: 918-770-4421

Wisconsin: 414-600-5383

Massachusetts: 781-202-1629

New Jersey: 609-955-3711

Pennsylvania: 215-399-9244

****Order is valid for one year unless otherwise noted****

Revision Date 9/2025